	MENTAL HEALTH ISSUES	
	POLICY NUMBER: 41-7	ISSUING AUTHORITY
	EFFECTIVE DATE: January 1, 2025	Christine A. Elow Police Commissioner

I. GENERAL CONSIDERATIONS AND GUIDELINES

Police officers are often first responders for persons experiencing a mental health crisis; and on these calls may be required to protect from harm the person experiencing the crisis, family members, mental health workers, and others nearby. The move away from hospital-based services to community-based services in addition to the availability of more effective medications has increased the likelihood of police involvement. The requirement and need for police to be trained in and respond to mental health calls for service is an example of the expanding role of police in modern society.

II. POLICY

It is the policy of the Cambridge Police Department that:

A. all officers will be trained in crisis intervention techniques, including those techniques specifically related to the safety of persons with mental health conditions and related disorders and the safety of all persons who come in contact with them;

B. officers will be trained to recognize mental health and related disorders, to enlist the help of mental health professionals, and to intervene in a crisis in such a way as to reduce the possibility of injuries to anyone involved; and

C. persons suffering from mental health and developmental conditions will be afforded the same rights, protections, and respect as all other citizens in the community regardless of any stigma that some people may associate with those conditions.

III. DEFINITIONS

A. *Bipolar*: Formerly known as manic-depressive illness, the disorder is associated with extreme swings in a person's mood, emotions, and behaviors. In the manic state, these strong moods may include intense elation or irritability. In the depressive state, deep sadness or hopelessness is prevalent. Both are manifested in the mixed state.

B. *Delusions*: Fixed false beliefs, such as, *everyone is out to get me*.

C. *ECD*: Emergency Communications Department.

D. *Hallucinations*: Perceptual experiences that are not actually occurring, such as hearing voices telling one to harm oneself.

E. *Pink Slip* or *Section 12*: Refers to an involuntary commitment to an emergency mental health facility pursuant to M.G.L c. 123, § 12.

F. *Schizophrenia*: A serious disorder that affects the way a person thinks, feels, and acts. The illness is characterized by dramatic changes in behavior and thinking. Someone with schizophrenia may have difficulty distinguishing between what is real and what is imaginary; may be unresponsive or withdrawn; and may have difficulty expressing normal emotions in social situations.

G. *Stigma*: A mark of disgrace associated with a particular circumstance, quality, or person.

IV. PROCEDURES

A. 41.2.7 (M) Mental Health Issues

1. Recognizing signs and symptoms of mental health issues is a first step in the proper handling of a mental health call for service and an important factor in achieving a good outcome.

2. Factors that may aid in determining if a person is suffering from a mental health condition include the following.

    a. Severe changes in behavioral patterns and attitudes.

    b. Unusual or bizarre mannerisms and/or appearance.

    c. Distorted memory or loss of memory.

    d. Hallucinations or delusions.

    e. Irrational explanation of events.

    f. Hostility to and distrust of others.

    g. Fear of others, such as paranoia.

    h. Marked increase or decrease in energy.

    i. Lack of cooperation and tendency to argue.

    j. One-sided conversations.

    k. Lack of insight regarding their mental illness.

3. These factors are not necessarily, and should not be treated as, conclusive. They are intended only as a framework for proper police response. It should be noted that a person exhibiting signs of an excessive intake of alcohol or drugs may also be suffering from a mental health condition.

B. Common Mental Disorders

1. Bipolar Disorder: This may be a lifelong illness that most often begins in the later teenage years or early adulthood. It commonly runs in families, but not always, and affects more than two million Americans. It is a treatable illness.

   a. Warning Signs: These signs, outlined in the chart below, are often painful, last a long time, and are serious. They can interfere with a person's ability to conduct normal family, work, and personal lives.

Signs of Mania	Signs of Depression
Excitability or feeling high	Feeling sad, depressed, or guilty
Increased talkativeness	Slow or sluggish behavior
Fast speech	Hopelessness
Decreased need for sleep	Thoughts or plans of suicide
Excessive energy	Change in sleep, appetite, energy
Risky behaviors	Problems concentrating

   b. Some people will self-medicate with alcohol or drugs.

2. Schizophrenia: Persons in a psychotic state may have high anxiety, faulty reality testing, poor judgment, or diminished impulse control.

   a. They may be at risk of harming themselves or others.

   b. Warning signs include the following.

      (1) Delusions.

      (2) Hallucinations including hearing, smelling, tasting, or feeling something that is not really there.

      (3) Disorganized speech and/or lack of speech.

      (4) Bizarre behavior.

      (5) Blunted or dulled emotions.

      (6) Withdrawing emotionally from people.

      (7) A loss of interest in school or work.

      (8) Difficulty paying attention.

      (9) Lack of energy and motivation.

      (10) Suicide ideation or attempts.

      (11) Outbursts of anger.

      (12) Poor hygiene and grooming.

3. Depression: Depressive Disorder is more than just feeling sad or a little under the weather.

a. Depression is a mental illness that can seriously affect a person's feelings, thought patterns, behavior, and quality of life.

b. Warning signs include the following:

(1) Ongoing sad, anxious, or empty feelings.

(2) A loss of interest in activities that normally are pleasurable, including sex.

(3) Appetite and weight changes, either loss or gain.

(4) Sleep problems including insomnia, early morning wakening or oversleeping.

(5) Irritability.

(6) A loss of energy and a sense of fatigue or being slowed down.

(7) Feelings of guilt, worthlessness, and helplessness.

(8) Feelings of hopelessness and pessimism.

(9) Difficulty in concentrating, remembering, and making decisions.

(10) Suicide ideation or attempts.

(11) Ongoing body aches and pains or problems with digestion that are not caused by physical disease.

4. Other common disorders include anxiety, Alzheimer's, PTSD and other stress-related disorders, psychotic disorders, hoarding disorders, and delirium with extreme agitation.

C. Accessing Community Mental Health Resources

1. EMS is available 24/7 for transportation to a local hospital. EMTs on the ambulance will determine the best destination hospital based on distance and availability.

2. Officers shall conduct a pat frisk for weapons or objects that could be used to cause harm before a patient is placed in the ambulance and transported to the hospital. The pat frisk shall be conducted for patients who are seeking mental health treatment voluntarily or involuntarily.

3. Subjects will be taken to a nearby emergency room for evaluation. In most cases, hospitals in the Cambridge area include Mass General, Mount Auburn, and Cambridge Hospital.

4. Officers will follow the ambulance in a department vehicle, accompany the subject into the emergency room, and provide all pertinent information to the ER attendant. These procedures shall be followed when EMS personnel request such, when the patient is combative, or when there is a Section 12 order, or as exigent circumstances dictate.

D. Guidelines for Working with Persons Suffering Mental Health Issues on the Street and During Interviews and Interrogations

1. Field Contacts

a. If officers believe they are responding to a mental health crisis, they should not proceed in haste unless circumstances dictate otherwise.

b. Before making decisions, officers should learn as much as possible about the subject. It is especially important to learn whether any person, agency, or institution presently has lawful custody of the subject, and whether the subject has a history of criminal, violent, or self-destructive behavior.

c. The officer, in consultation with a supervisor, may call for the mobile crisis team, confer with EMS personnel, and request ECD to call a crisis center, if needed. The ECD should have telephone numbers and locations of crisis centers.

d. It is not unusual for such persons to employ abusive language towards others. Officers and civilian employees should ignore verbal abuse when handling such a situation.

e. Avoid excitement. Crowds may excite or frighten a person experiencing a mental health crisis. Groups of people should not be permitted to form nearby or should be dispersed if possible.

f. Reassurance is essential. Officers should attempt to keep the person calm and quiet, to show friendliness, and the desire to protect and help. It is best to be honest, avoid trickery, and to be alert to the potential for violent behavior.

g. Officers should always act with respect, not talk down to, or treat a subject as child-like. A person with mental health issues may be both highly intelligent and acting irrationally.

2. Interrogating/Interviewing

a. Whenever a subject suffering from a mental health condition is a suspect and is taken into custody for questioning, police officers must be particularly careful in advising the subject of their *Miranda* rights and eliciting any decision as to whether they will exercise or waive those rights. It may not be obvious that the person does not understand their rights.

b. In addition, it may be useful to incorporate the procedures established for interrogating juveniles when an officer seeks to interrogate a suspect who is suffering from a mental health condition or is developmentally challenged.

c. Before interrogating a subject who has a known or apparent mental health or developmental condition, police should make every effort to determine the nature and severity of that condition, the extent to which it impairs the subject's capacity to understand basic rights and legal concepts such as those contained in the *Miranda* warnings; and whether there is an appropriate *interested adult*, such as a legal guardian or legal custodian of the subject, who could act on behalf of the subject and assist them to understand their *Miranda* rights and in deciding whether or not to waive any of those rights in a knowing, intelligent and voluntary manner.

E. Confidentiality

1. Any officer having contact with a subject who is suffering from a mental health condition shall keep the matter confidential except to the extent that revelation is necessary for conformance with department procedures regarding reports or is necessary during official proceedings.

F. Responding to Requests for Assistance

1. If an officer receives a complaint from a family member of a subject who is allegedly suffering from a mental health condition, the officer should assess the person's mental state. The officer should make a good faith determination as to whether there is reason to believe that failure to hospitalize the person would create a likelihood of serious harm by reason of mental illness, and as to whether the person is a threat to themself or others.

2. If a person is not an immediate threat or is not likely to cause harm to themself or others, officers should advise family members of that determination. The family member may consult a physician or mental health professional to obtain a commitment from that person pursuant to M.G.L. c. 123, § 12(a); or make application to the district or juvenile court to obtain a warrant of apprehension pursuant to M.G.L. c. 123, § 12(e).

G. Involuntary Commitments

1. A Section 12(a) refers to an involuntary commitment to an emergency mental health facility for an evaluation pursuant to M.G.L. c. 123, § 12(a). A form regarding Section 12(b) is signed by a physician after an evaluation determines that the subject should be committed to a facility.

2. Police Application of M.G.L. c. 123, § 12(a)

   a. If feasible, a police officer should seek the involuntary commitment of a subject by an authorized mental health professional or the court.

   b. Absent an order of a physician or psychologist for involuntary hospitalization, a police officer may convince a person who they believe needs such services to agree to a voluntary admission for a mental health evaluation.

   c. Commitment proceedings under M.G.L. c. 123, § 12(a) should be initiated by a police officer only if all the following procedures have been followed.

      (1) The officer has no knowledge of any outstanding commitment orders pertaining to the subject.

      (2) Every reasonable effort has been made to enlist an appropriate physician, psychiatrist, psychologist, social worker, or family member to initiate the commitment proceedings.

      (3) The officer has notified a supervisor if there is not one on the scene already.

   d. Officers may make a warrantless entry into the home of a subject for whom a Section 12 has been issued, provided:

(1) they have actual knowledge of the issuance of the Section 12(a);

(2) the entry is of the residence of the subject of the Section 12(a);

(3) the Section 12(a) was issued by a qualified physician, psychologist, licensed independent social worker, or psychiatric nurse in an emergency; and

(4) the warrantless entry is made within a reasonable amount of time after the Section 12(a) was issued.

(5) NOTE: If any one of the above criteria is not met, and unless exigent circumstances are present, a warrant or consent shall be obtained prior to any entry of a residence to execute a Section 12(a).

e. Whenever practical, contact should be made with the receiving emergency mental health facility prior to transporting the subject. This may be done by an officer, a dispatcher, emergency medical personnel, or staff from the facility from which the subject is being transported. The facility should be informed of the circumstances and any known clinical history.

(1) The officer accompanying EMS shall remain with the subject until custody is transferred to the hospital staff.

f. A Section 12(a) has no expiration date. However, as a matter of best practice, if a Section 12(a) is outstanding for more than 48 hours prior to being served, the issuing authority should be re-contacted to confirm that the Section 12(a) commitment is the best course of action for the subject named on the order.

3. A person suffering from a mental health condition may be taken into custody if:

a. they have committed a crime for which there is a right of arrest;

b. the officer has a reasonable belief that the subject poses a substantial danger of physical harm to themself or others. Threats or attempts at suicide should never be treated lightly.

4. At all times, an officer should attempt to gain voluntary cooperation from the subject.

5. Officers shall be bound by use of force requirements consistent with the department policy on Use of Force. For any incident in which any level of force is used in placing a subject in custody for a mental health commitment, there shall be a Superintendent-level debrief and response no later than 24 hours after the subject has been admitted to the hospital. The Superintendent conducting the debrief shall inform the Police Commissioner regarding the facts and circumstances of the incident as soon as possible.

H. Transporting to a Treatment Facility

1. Generally, a person who is to be transported to a hospital for a mental health evaluation pursuant to M.G.L. c. 123, § 12 will be transported by ambulance.

2. A police officer may transport a subject in a police vehicle equipped with a protective barrier if, in the opinion of the officer, the subject poses a threat due to violence, resisting, or other factors. Authorization from a supervisor should be sought prior to transport.

I. Indemnification

1. Police officers are immune from civil suits for damages for restraining, transporting, applying for the admission of, or admitting any person to a facility**.**

2. Immunity applies to officers acting pursuant to the provisions of Chapter 123 (Mental Health).

J. Lost or Missing Persons with Mental Health Issues

1. If a person suffering a mental health or developmental condition is reported lost or missing, police shall follow protocols described in the department policy on *Missing Persons*.

2. Officers may additionally refer the family of the missing person to the National Alliance for the Mentally Ill (NAMI)/Homeless or Missing Persons Service which operates an emergency hotline. The Information Helpline telephone number is 1-800-950-NAMI (6264), and the web site is http://www.nami.org/ .

K. Training

1. Documented entry-level training shall be conducted in the academy according to Massachusetts Municipal Police Training Committee standards. Department personnel shall be trained in this policy upon initial employment**.**

2. Employees shall receive documented refresher training annually.